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ORIGINAL ARTICLES

DIAGNOSIS OF UPPER ABDOMINAL SYMPTOMS.

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The one and only reason for performing an operation, is that the patient upon whom it is performed might be relieved of the symptom or symptoms for which he seeks relief. It has been said, and we all have found it to be true, that "nothing succeeds like the patient getting well." It is, therefore, of the utmost importance for the patient—since he does not wish a needless or useless operation—and also for the surgeon—since he wishes his patient to be cured, if possible, after the operation — that the surgeon and physician should be able to properly interpret the "signs at the crossroads," in order to be able to relieve the pathological condition underlying the patient's symptoms.

Most any surgeon who has had experience and has a thorough knowledge of anatomy and abdominal physiology, combined with surgical judgment and technical skill, can successfully execute the mere mechanical performance of an operation, provided, also, he has the necessary facilities for asepsis, etc., at his command. But to successfully perform an operation, without a close study of the patient and his symptomatology with a view to making a careful and painstaking diagnosis, will result in many needless operations and woeful disappointment to both the surgeon and his patient. In considering a diagnosis of diseases of the upper abdomen, there is no surer foundation on which to lay the facts, which are to be considered in reaching a correct diagnosis, than an accurate and complete clinical history of the case, including a careful analysis of the "story" regarding the condition of which the patient is at present complaining. This will usually *point the way* for further investigation, and if none of the minor details are neglected, will in almost every case reveal the disease from which he is suffering. Of course, the most important facts that are brought out in this history are those which have to do with the history of the present illness. They should be carefully studied and accurately interpreted. If pain is complained of, note its *situation*, its *duration*, and whether *referred* to other localities. Find out its relation to digestion. Note whether it occurs before or after eating, or in what manner, if any, it is affected by the taking of food. If *vomiting* is a symptom, note the *manner*. Is it expulsive, or does it come up without effort? Note its *character*. Is it mucous, simple undigested food, bile-stained, bloody, or fecal? Note also its *relation to digestion*. Does it occur immediately or long after a meal? In this way we are often able to estimate roughly whether or not there is *stasis*, which is very important with reference to certain obstructive conditions at the pylorus. Is this pain and vomiting associated with, or is there independently an area of *tenderness?* If so, note its location, its degree and duration, and whether or not it is associated with regidity of the muscles. Inquiry should be made relative to the patient's *weight, temperature*, and the presence or absence of jaundice. Note also if there were *chills* and *sweats*. In most cases it is advisable, and in all cases where the facilities are at hand, it is helpful to have an *examination of the stomach contents* and *feces*. *A blood count, both red* and *white cells*, and a differential count should be made, together with an estimation of hæmoglobin, and in the presence of jaundice, an estimation also of the *coagulation time*. The usual

chemical and microscopical examination of the urine should be made, and the *frequency, urgency, quantity,* and whether it is necessary to *void at night,* should be noted; and *in addition kidney function* should be determined by means of the phthalien or indicocarmen tests. I realize that what I have said is very general in *character,* and *also* quite elementary; but at the same time a careful inquiry into the patient's history and symptoms is most *neglected,* and my excuse for reviewing these facts is because I believe that physicians who have failed to get results with their dietetic and hygienic measures in diseases of the upper abdomen are more and more inclined to consult a *surgeon,* who not only can perform any necessary surgery, but can also tell them what is the matter with their patients. Now I wish to briefly consider the symptomatology of the upper abdomen, with reference to the special diseases affecting the various organs in that locality.

The stomach has been called the "mouthpiece of the abdomen," and *"indigestion"* is its language. The crying out of the *stomach* for relief of *pain, anorexia, vomiting,* etc., does not always mean *"stomach diseases."* "Stomach symptoms" are due to disease of the stomach itself in less than 10 per cent cases, according to Dr. Deaver; and at the Mayo clinic they have found that a "large percentage of patients presenting themselves with gastric symptoms, and who undergo an operation, show at the time of the operation no demonstrable lesion of the stomach or duodenum." Surgeons have found from a study of living pathology, at the operating table, that gall bladder and appendix disease make up the *major* percentage of diseases having a dyspeptic syndrome. There are cases also which come to us suffering from "disturbances of digestion," in which it is almost, if not quite, impossible to say whether the disease is of the stomach, duodenum, gall bladder, or appendix. Of course, purely medical diseases give symptoms in the epigastric region, and they must not be forgotten. For example the dyspepsia and anginoid pains of coronary sclerosis, myocardial disease, or the gastric crises of tabes.

So much for the symptoms known as "indigestion," collectively and in a general way. Before referring to the different diseases of the upper abdomen, just a word about some of the individual symptoms themselves. The character of pain depends upon its cause, and pain in the abdomen may occur from two special causes, according to Beckman. "First, from contraction of walls of a hollow viscus. Second, inflammation plus muscular spasm. Pain resulting from the first cause is always *severe* and *rythmic, i. e.,* colicky in type, as for example the pain of severe renal colic, gall-bladder colic, or intestinal colic, due to obstruction. No other pain, except the *pain of perforation,* compares in severity with this type, and the *pain of perforation* differs from this pain in that it is *constant* and *never colicky.* Pain from the second cause, *i. e., pain due to muscular spasm,* in an attempt on the part of nature to place at rest an inflamed area, is more or less constant, but at times gets more severe. The muscles that are attempting to hold the part immovable, occasionally relax and then contract again, causing occasional increase or exaserbation of the pain. This type is seen in subacute or slow perforation, appendicitis and peritonitis."

In addition to the two causes for "pain in the abdomen," given by Beckman, there is another cause given by Dr. A. D. Bevan in a very instructive and interesting discussion of "gall-bladder disease." He does not think that the pain of gall-bladder disease, stone in kidney, or ureter, etc., is solely mechanical in organ, that is due to peristaltic action, although it may be, but there is usually an infection of the gall bladder with obstruction of cystic duct causing pus or mucous accumulations and greatly distending the gall bladder, and it is this intracystic tension which is the cause of the pain. Under these conditions a cholecystotomy, or in the case of the kidney a nephrotomy which relieves the *tension,* will relieve the pain, although the obstruction in the cystic duct or ureter may still exist.

Lesions of the stomach and duodenum do not produce the first type of pain mentioned above, although they are hollow organs and the pain is often due to spasm, because they can more easily empty themselves, since the obstruction is never so complete in this locality and the stomach can readily empty itself, even in the presence of complete pyloric stenosis through the esophagus. Therefore, when pain is of a *severe colicky nature*, the cause should be looked for outside of the stomach. Another differential *point is that if pain occurs immediately upon taking* food, especially if it is accompanied by vomiting, it is apt to mean a severe contraction of the stomach, *due to reflex conditions* and caused by some disease outside of the stomach itself. However, if pain is present with *periodic regularity between meals*, especially if relieved by food or an alkali, it usually means disease of the *stomach* or *duodenum*. If the pain is constant, and unaffected by food, it may be due to disease of the stomach or to some lesion outside the stomach.

Nausea is not a characteristic symptom of lesions in the stomach or duodenum; it is present in stomach, pancreatic, gall-bladder, kidney, and appendix disease. It is only slight and usually periodic in stomach and duodenum disease and it is prolonged and continuous in gall-bladder disease. We must also remember the nausea and vomiting of pregnancy in interpreting this symptom. Cases have been sent to the radiologist for examination to determine the causes of nausea and vomiting, when a vaginal examination would have made the diagnosis.

In making a diagnosis of upper abdominal symptoms, the most common conditions, aside from purely medical diseases, we have to take into consideration gastric and duodenal ulcer, kidney stone, gall-bladder disease (with or without stones), pancreatitis, acute and chronic appendecitis and high intestinal obstruction. The diagnosis of such symptoms would rest on the *history*, the presence or absence of colic, the pain—its character, location, and transmission or radiation—the presence or absence of tenderness and its location, and the results of a thorough study of the findings after gastric analysis, blood counts, urinary analysis, and radiographic examination.

Gastric and Duodenal Ulcer. This is the most common lesion of the stomach and duodenum. In a typical case of duodenal or gastric ulcer there is usually a very characteristic *history*. In the first place there is a decided *chronicity* to the *symptoms*, and there is not really severe pain, never intense and colicky, but rather a feeling of discomfort, of a gnawing or burning character. This pain comes on several hours after eating, usually three to five hours, and is relieved by taking food or some alkali, usually bicarbonate of soda. According to Graham, quoted by Beckman, "The longer the period between food intake and the onset of symptoms, the lower the ulcer, as a rule. The more prompt the ease from food and the cessation of symptoms, the lower the ulcer." The *appetite* is good and *vomiting* is uncommon, except there may be *acid* eructations. These symptoms have also definite *periodicity*. They may occur, with only slight, if any, variations each day, and without any apparent cause and return again in a few weeks or months. There may be a definite point of tenderness, and, if so, it is apt to be to the left, in the epigastrium. This pain or distress may or may not be transmitted, but if it radiates to the right, it is more apt to be duodenal, and if to the left it is more apt to be gastric. The examination of gastric contents and X-ray examination will usually clear up the diagnosis. There is usually a hyperacidity, and if there is pyloric stenosis or hour-glass stomach, there will be the evidence of disturbed motility, and a few yeast and sarcinae. Occult blood may, or may not, be present in the stomach contents, but, if present, is not of positive diagnostic importance, but if present persistently in the *stools*, is extremely suggestive and helpful in diagnosis.

It is of greatest importance to remember that the diagnosis of ulcer is to be made on the subjective symptoms (the *history*) rather

than the *clinical findings*. Physical examination and laboratory findings are helpful aids in clinching the diagnosis. The history should be elicited by indirect rather than direct questioning and should go back to patient's early life.

In a recent issue of the *Boston Medical and Surgical Journal*, Dr. T. Bottomley reports his work on the stomach and duodenum for 1917, and says: "For the surgeon working under conditions which usually obtain, he values diagnostic means in the following order: (1) The *clinical history;* (2) the roentgenologic examination; and (3) chemical and laboratory tests.

Gastric Carcinoma may pursue a latent course, and exist undiscovered for a long time. The cachexia, palpable tumor, gastric motor insufficiency, absence of hydrochloric acid and presence of lactic acid and Boas-Oppler baccilli, dark "coffee ground" blood in gastric contents, and the filling defects discovered by X-ray, especially if taken in consideration with a chronic history of "stomach symptoms" (as indigestion, pain, etc.), make a diagnosis of gastric cancer comparatively easy. Unfortunately these symptoms are rarely all present, except in the *late stages*, and none of the above symptoms taken separately are pathognomonic. John B. Deaver, in an article on "Early Recognition of Carcinoma of the Stomach," *New York Medical Journal*, May 3, 1919, says, "There is perhaps no more insidious disease than carcinoma of the stomach. The X-ray and laboratory methods are not infallable. When carcinoma can be diagnosed by clinical signs it is generally too far advanced for more than palliative measures. One way of curing carcinoma is to avoid its development by operative removal of ulcers, a certain percentage of which are known to develop malignancy." The diagnosis of gastric carcinoma, despite the multiplicity of modern methods of scientific investigation, is a problem of the greatest magnitude, especially in *early cases*. The insidious development of the disease is often the cause of *diagnostic failure*, and Pope and Willmoth, of Louisville, Kentucky, think that "*surgical exploration* must be included among the diagnostic methods in doubtful cases."

The *symptoms* which more definitely refer to the *gall bladder* are: The colicky *character* of the pain, its *location* and transmission to back and shoulder; jaundice, in case of any common or hepatic duct obstruction, a *palpable tumor*, in some cases of a large number of stones in gall bladder, or in empyema, or cystic gall bladder, where the cystic duct is obstructed; and the *location* of the *most marked tenderness* just over the gall bladder, about the junction of the ninth costal cartilage and the right semilunar line, elicited and located by the *Murphy method* of finger percussion.

The X-ray may or may not be of service in diagnosis of gall *stones*. It is of decided value, after an opaque meal, to eliminate an appendix pointing in direction of gall bladder; and also will show adhesions in neighborhood of duodenum or elsewhere in gastrointestinal tract. It is claimed that any gall bladder that shows on X-ray plate is pathological. The following case will illustrate the value of a complete radiological examination:

Patient (W. M.), male, age 48 years, fat (weight, 235 pounds), single, lawyer and farmer; always been a heavy eater and cigarette smoker. Drinks alcohol moderately and rarely. Venereal history negative. Chronic constipation. Family history negative and past personal history negative, except for history present illness.

Cannot remember exactly when he began to have periodic attacks of severe pain in epigastrium, associated with nausea and vomiting. Vomiting seemed to temporarily relieve pain. No jaundice during or subsequent to attacks of pain. Urine normal. Gastric contents showed slight hyperacidity. Alkalis (milk of magnesia and soda) sometimes relieved for a while. Never vomited any blood; has never lost weight. Has good appetite; no fever during attacks. Attacks last two or three days, and between attacks he is free from subjective symptoms. Physi-

cal examination: During attacks locates point of greatest tenderness over right side, about one inch below junction of ninth costal cartilage and semilunar line. Are these attacks due to gastric ulcer, gall-bladder disease, or is there some reflex cause in the lower abdomen? The Roentgen examination of the gastrointestinal tract, made by Dr. L. A. Cunningham, who is an expert radiologist, is as follows:

"The heart and chest look normal with the screen examination and vessel shadows show on enlargement.

"The food passes readily down the esophagus and shows no delay or spasm or irregularity.

"The stomach shows good tone and empties rather rapidly even for a high stomach of the transverse type as you would expect with his build.

"The bowel shows a general delay in emptying, and he has a long appendix arising from the inner border of the cæcum and running upwards and then curling around on itself and looks to be about nine inches long and shows signs of being poorly drained.

"The meal does not show any organic lesion of the duodenum or the stomach, nor does the enema show a lesion of the colon.

"The rapid emptying of the stomach suggests the possibility of a gall-bladder lesion, but is only suggestive. There is a definite, long, poorly-drained appendix. He also undoubtedly overeats and overworks his digestive organs. Gall-bladder examination negative."

Another case (P. L.), age 42, male, married, fat, editor, always been heavy eater and cigarette smoker, drinks moderately, venereal history negative. All history and examination negative except periodic attack of intense pain in epigastrium, tender to touch, most marked over gall bladder, associated with vomiting. Relieved by hypomorphine and all right for weeks or months, until another attack. Is usually constipated.

Roentgen examination shows:

"All parts of the tract are negative for an organic lesion except the appendix and the gall bladder.

"The appendix show an enlargement of calibre for the last inch, tip end, and shows a retention of barium food. This would indicate a chronic catarrhal lesion.

"There was considerable pylorospasm and some residue of food at the end of six hours. With the absence of an organic lesion and no tenderness about the appendix, and the history, the gall bladder would be guilty of being primary in my opinion.

"No gall stones nor gall-bladder shadow nor adhesions of the duodenum in the gall-bladder region could be demonstrated. Neither could any renal calculus be shown.

"Colon outlined normally with the barium enema and showed some leak into the small bowel. He also expelled most of the enema.

"I believe that you have a gall-bladder lesion, although the appendix has to be considered and that the attacks he has are exaggerated attacks of *pylorospasm*."

These two cases show the difficulty of making a differential diagnosis between stomach, gall bladder, and chronic appendix conditions, and the absolute necessity of a careful study of each case, and a thorough use of all the means at our disposal for diagnostic purposes.

Space and time will not permit me to take up each disease in the abdomen that is sometimes associated with upper abdominal symptoms, but appendicitis, which is the most common of all inflammations in the abdomen, must be alluded to. We are all familiar with the symptoms of acute appendicitis, but it is well to remember the teaching of the late John B. Murphy, with reference to the *sequence of symptoms* in that condition. *First pain* (around umbilicus or more or less general in abdomen, later localizing in right iliac fosa); followed by nausea (probably vomiting); tenderness most marked over McBurney's point. Rigidity, or at least increased resistance of right rectus; fever, and increased leucocyte count, both total and polymorphonuclears. In chronic appendicitis

the symptoms are less definitely localized to the right lower quadrant of the abdomen.

In a female, it is always important to exclude inflammations of the tubes or ovaries in making a diagnosis of pain in the lower abdomen. Pain in lower abdomen, right side, in a female under twenty, with an *intact* hymen is almost always appendicitis. If married, or unmarried, a vaginal examination should be made in all women suffering acute pain in the abdomen. In a virgin the examination of vagina may stop at inspection, if an intact hymen is noted. An article, appearing in *Southern Medical Journal*, August, 1919, quotes Dr. Koehler, of Portland, Oregon, as follows with reference to "misleading stomach symptoms," which absolutely coincides with my experience:

"The more common lesions which give rise to symptoms referred to the stomach are appendicitis, arteriosclerosis, tuberculosis, gall-bladder diseases, locomotor ataxia and pelvic disorders. In the earlier stages of appendicitis the symptoms are frequently referred to the stomach. It is easy to be misled when the anatomic relation of the appendix is not normal. Many of our dyspeptic patients, especially men who work constantly in an atmosphere of worry and nerve tension, whose bodies have become saturated with toxins due to the excessive use of alcohol, tea, coffee, and tobacco, may be suffering from sclerotic changes. Almost every case of tuberculosis sooner or later shows some disturbance of the digestive organs. Many such cases come to us with gastric derangements long before the occurrence of signs which point directly to a lung involvement. In the same manner the gastric crisis is frequently the first manifestation in tabes dorsalis. Acute attacks of gall-bladder infection give rise to nausea and epigastric pain frequently relieved by induced vomiting. The gynecologist, today, is curing gastric distress by correcting pelvic lesions. He repairs injuries, replaces organs and removes septic conditions with the best results. The care of the female genital organs is a most valuable aid in the treatment of disorders of the stomach in women, and treatment directed to the digestive organs is frequently a failure because a correct diagnosis has not been made."

I have just recently operated on a lady, and have apparently cured her of very distressing nausea, by a perineal repair amputation of an ulcerated and sclerosed cervix, and replacement of retroflexed uterus.

Kidneys: Examination of urine (pus and blood), fist percussion over kidneys, and a consideration of the pain, its character and radiation, will usually detect any cause for symptoms which might be connected *with the kidneys.*

It is quite easy to get into a *"rut"* in the practice of medicine and surgery, and frequently from want of *time* or proper facilities we do not fully examine our patients before prescribing.

Many patients have come to me complaining of vague indefinite symptoms, indigestion, pain, etc., who tell me that they have had two or three doctors and are no better. When I begin to take a history and request certain examinations, they inform me that they have never been examined before. I find them perfectly willing to be examined, and pay for certain special examination; they are anxious to know, if possible, what is the matter, and to be relieved.

Gentlemen, the doctor who fails to properly examine his patients and avail himself of all the aids to diagnosis that are available, these days, is doing not only the patient but himself an injustice. A prescription, or an operation, that does not relieve or cure the patient, has done neither the doctor nor the patient any good. No operation, or prescription, will be successful without a correct diagnosis based on a carefully taken history, and a thorough examination. As we have seen, it is not always possible to diagnose the exact condition present in every case, but we can save ourselves the embarrassment of treating medically a surgical condition, or vice versa, save ourselves the chagrin, and the patient the risk to life from an operation, to relieve symptoms due to a medical or non-

surgical condition, as arteriosclerosis, tuberculosis, locomotor ataxia, etc. It is always possible to diagnose "an acute or chronic surgical abdomen," and a surgeon should be consulted as soon as possible after such a diagnosis is made. Nothing is to be gained from delay. To wait after a diagnosis is made in a case of acute appendicitis, for instance, is to court disaster.

As the late Dr. Murphy said: "The only thing to wait for is pus, perforation, peritonitis and death."

In conclusion, let me repeat "nothing succeeds like the patient's getting well," which is a success both from the standpoint of the doctor and the patient. The patient can only get well if the proper diagnosis is made and the proper treatment instituted at the proper time, unless it be through "good luck," or the kind ministrations of nature.

THE DOCTOR AND THE DRUGGIST.*

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This subject, the relation existing between the doctor and the druggist, is one which has been discussed almost since the beginning of time, and has been covered most thoroughly by many more able to handle it than I. However, I think my close and most intimate relation with doctors, covering a little more than a quarter of a century, gives me a pretty definite idea of the facts as they exist today, have in the past, and as they should exist today.

If there are two professions which should enjoy the most cordial relations, it is those of the doctor and the druggist, though I am sorry to admit that such is not always the case. First, think of how dependent we are one on the other; then think of how dependent the public is on both. Does it not stand to reason that there should always be a kind and brotherly feeling between us?

You spend your five years of hard study to learn to diagnose and to prescribe; we, in turn, put in our school term in being taught how to scientifically compound your prescriptions, and to pull you out of deep water when it comes to incompatibilities. Each and every one of you frequently runs against this trouble, and that is one of the many instances when the druggist is a friend in need. You doctors, as a rule, soon forget the cursive course you complete covering posology and incompatibility, your mind is taken up at the time with what you consider matters of more importance, so right then and there you determine that it is something you will leave to the druggist; and right you are, for after all we are considered the doctor's safety valve—for no matter what you write for, or what size doses you prescribe, or whether or not the ingredients are compatible, it's up to us to know. The druggist and not the doctor is held responsible for the action of the medicine on the patient. Gentlemen, this alone should demand the existence of a most cordial feeling between the two professions.

I realize that the greatest sin of the druggist in the eye of the physician is that unforgivable "counter prescribing," while on the other hand the druggist would not survive many moons if you doctors persisted in dispensing exclusively. So you see we both have our grievances, be they real or fancied. However, I am happy to say that in Daytona and vicinity neither of these sins of commission are carried to excess. Personally I discourage counter prescribing most vehemently, and I do so conscientiously, though there are times when we are forced to it in a measure. Invariably my clerks are told that its practice is not desired in my establishments, and to always try and have a physician called when such cases present themselves.

My intimacy and real friendly relations with the doctors of Volusia county and particularly those in the immediate vicinity of Daytona, where I have been located for the past eighteen years, renders it next to an impossibility for me to sanction anything of an unethical nature.

*Read before the Volusia County Medical Society, at DeLand, December 17, 1919.

I realize you doctors do not sanction the development of recent years following our step from what you term an ethical pharmacy to that of the drug merchant of today, but, gentlemen, though it may appear to you that in taking this step we have commercialized our profession, I assure you that the true pharmacist is just as jealous of his prescription department today, if not more so, than ever before. Though the fronts of our present-day stores may resemble anything but the ethical pharmacy of a few years ago, I am positive that the majority of the prescription departments are better equipped today and in charge of more competent pharmacists than at any previous time. We are rapidly putting our stamp of disapproval on any kind of substituting to such extent that it has almost entirely disappeared. Not only that, but I think the stand the druggists have taken regarding the liquor question is a commendable one. By the laws of the nation we are allowed to handle and dispense liquors, but not one per cent of the druggists of the state of Florida have availed themselves of the opportunity — nor will they — for our State Pharmaceutical Association is working too hard for the betterment of our profession to stand for it.

In reading after an anonymous writer some time ago, I ran across the following lines under the caption of "My Guide," and I am going to suggest that they be carefully considered by each of the four professions represented here today. In case we see fit to live up to their teachings, I am sure it will make better and more thoughtful men of each of us:

"My Guide.

"To respect my country, my profession and myself.

"To be honest and fair with my fellowmen, as I would expect them to be honest and square with me. To be a loyal citizen of the United States of America. To speak of it with praise and act always as a trustworthy custodian of its good name. To be a man whose name carries weight with it wherever it goes. To base my expectations of reward on a solid foundation of service rendered; to be willing to pay the price of success in honest effort. To look upon my work as an opportunity, to be seized with joy and make the most of and not as a painful drudgery to be reluctantly endured.

"To remember that success lies within myself, in my own brain, my own ambition, my own courage and determination. To expect difficulties, and to force my way through them; to turn hard experience into capital for future struggles. To believe in my proposition, heart and soul; to carry an air of optimism in the presence of those I meet; to dispel ill temper with cheerfulness; to kill doubt with a strong conviction, and to reduce active friction with an agreeable personality. To make a study of my business, to know my profession in every detail, to mix brains with my efforts, and to use system and method in my work.

"To find time to do every needful thing by never letting time find me doing nothing. To hoard days as a miser hoards dollars; to make every hour bring dividends, increased knowledge of healthful recreation.

"To keep my future unmortgaged with debts; to save as well as earn. To cut out expensive amusements until I can afford them. To steer clear of dissipation and guard my health of body and peace of mind as a most precious stock in trade.

"Finally, to take a good grip on the joys of life, to play the game like a man; to fight against nothing so hard as my own weakness, and to grow in strength a gentleman, a Christian.

" 'So I maybe courteous to men, faithful to friends, true to my God, a fragrance in the path I trod.' "

AMERICAN COLLEGE OF SURGEONS.

ANNUAL MEETING HELD IN NEW YORK CITY, OCTOBER 20-24, 1919.

PRESIDENTIAL ADDRESS.*

WILLIAM J. MAYO, M.D., F.A.C.S.,
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The American College of Surgeons is beginning its seventh year under most inspiring circumstances. More than three-fourths of the Fellows of the Association have been in their country's service and have returned to their work with renewed vigor and enthusiasm. In spite of the war years, the College has made progress along all lines. The Clinical Congress of Surgeons of North America has been taken over by the American College of Surgeons. In the future the educational, scientific, and moral standards of the American College of Surgeons will be maintained, and only its members and invited guests will be welcomed to the clinical meetings.

Standardization of hospitals has made great progress under the able leadership of the Director of Education, Dr. John G. Bowman. As the result of the efforts of the College, the great majority of hospitals in America of more than 100 beds will institute the restricted staff, and install the laboratory facilities and record systems which the American College of Surgeons believes to be essential.

It is the desire of the Founders of the American College of Surgeons that the association shall be democratic, and that its membership shall be open to all those men of sterling character, ability, and training in general surgery and in the various surgical specialties, who are within the limits of North America. For, when all is said and done, the College stands for service to all the people, and unless a sufficient number of men of high ideals and professional qualifications is eventually secured, the organization will have failed to live up to its great opportunities.

The exact number of men required to perform the duties of caring for the various serious surgical ills of the 115,000,000 people of North America is at this time a matter of speculation and, so far as I know, there are no data on which such a computation can be based. However, an estimated number might be fixed to serve as a target for criticism, of at least one surgeon to 10,000 persons. This percentage is about the same as that furnished to England by the Royal College of Surgeons of London. That there will be, in the next decade, such a number of eligible men, I am confident. Objection has been raised to an association of so large a membership; it is maintained that this would mean a lowering of educational standards. If the principle is established that the association first of all is for the benefit of the people, I believe a working arrangement can be made which will, in a tentative way, meet the requirements. The next generation will not be so greatly troubled as the present one by questions of educational standards. The medical standards of the whole country have been raised to a point not exceeded by those of any other country in the world. In the present generation, by reason of divergent standards, there will have to be a certain amount of latitude to meet the existing conditions.

Knowledge obtained by observation, experience, and from the printed page, is possessed by many men. When knowledge is translated into proper action we speak of it as wisdom. Many men have great wisdom, in their knowledge of useful things, yet may have but a limited book learning. Personally, I believe that the wise honest man who can bring a higher order of skill to bear on surgical infirmities should not, at least in this generation, be refused admission to the College because of a lack of fundamental training.

In the adoption of standards or requirements for admission into the American College of Surgeons, character should be first

*Delivered at the Seventh Convocation, New York City, October 24, 1919.

considered. The dishonest, conscienceless man who has surgical skill is most dangerous in any community. Unnecessary operations, even when performed with a high order of technical ability, are the bane of present-day surgery, but, owing largely to the American College of Surgeons, such practices are markedly on the wane. However lenient we may be in estimating the value of the older and disappearing generation of surgeons, our standards for the younger and coming generation of surgeons, who have had and who will have had opportunities to acquire learning, should be high and increasingly high as future standards and educational requirements are raised.

In the future, the American College of Surgeons will not only demand that the candidate shall be a graduate of a reputable medical school and have had hospital experience and be licensed to practice, but also that he shall have had special training in the particular surgical specialty which he intends to practice. In making these requirements it is the duty of the College to see that facilities for obtaining the special training are developed. Three years at least will be required for such special training. At the present time the man who possesses the B. S. and M. D. degrees and has had one year of hospital training averages 27 to 28 years of age. Add three years to this training and he is 30 to 31. Will this secure the best results or will the man reach his life work at too late an age? We must also consider that during the entire period of his education he is not self-supporting. Will not this have a tendency to make the surgeon a member of an aristocracy to the ranks of which the sons of rich men will be the only ones who will have easy entrance? Investigation was made of the professional standing of the graduates of the medical department of the University of Michigan fifteen years after graduation. It was shown that those who graduated before their twenty-fifth year had made, on the average, greater scientific progress and were a greater asset to their community than those who graduated after the twenty-fifth year.

I think we are all agreed that the actual time spent in the professional part of this education should not be shortened. I think we are also agreed that one of the faults of the educational system of our country is a loss of time and effectiveness in the preliminary educational methods. The university has been made the base of our educational system and it should be the apex. Only a small percentage of those who enter our public schools ever reach the university, yet the university greatly influences the educational policy even in the grade schools. I am convinced that at present two years of time are lost in the grade schools, and that the education given is not altogether the most desirable for the making of American citizens. A six-year course of grammar school education, divested of any university significance, should be a strict government requirement in all schools, private as well as public, and given in the American language. It should be the purpose to give a common education in the common things that are to make us a united people, and such an education might well be made a requisite for the exercise of suffrage.

The high school could be reduced to three years instead of four, and in it for the first time should the university be considered. Languages should be optional in the high school, but I believe that Latin and modern langtuages are of great value to the professional man. The high school now recognizes the material facts of life, and gives an education in mechanics and agriculture, business, and the industries, as well as the traditional cultural education, and these courses should be further extended.

It is sometimes difficult to follow the academic mind. The more or less cloistered life that is led by many college professors has given traditional cultural education too great an influence. Modern educators today do not believe that teaching in one subject as, for instance, mathematics, has greater power of mental training than other subjects. The old time educator would consider this rank heresy. His mind still clings to the view that

any education which might be used commercially is not cultural, a view which is wholly undemocratic and based on an outworn caste system.

In no place has this traditional view of education been more pronounced than in the universities. It has been only within recent years that the university faculties would accept the view that the anatomy and physiology of man had cultural training value, although they were convinced that the anatomy and physiology of plants had such value. There has been a slowness of universities to give credits for any kind of work which might be used for gaining a livelihood, even so holy a cause as caring for the sick. And today, less credit is given in these subjects than for others which have no more training value. Do not understand me as desiring to lower the standards of universities in relation to cultural education. Far from it; but I do object to the present attitude which desires to force every type of education into the one mold. The great problem now is to obtain the money to give an education to all those who desire it. The purpose of the university is to give an education not to the few, but to the many; and it should be emphasized that the giving of degrees is only incidental to this purpose. Every unnecessary step, every unnecessary regulation which delays or obstructs the progress of a student prevents some one else from obtaining an education. The academic answer is: Raise standards until the number of those who can — not desire, but can — obtain an education is reduced to the number who can be given the present form of education. Our country depends not on a cultured class alone, but on the average intelligence, and in the last analysis on the number who will be able to obtain an opportunity to get an education. It should be the duty of the Fellows of the American College of Surgeons to see that certain existing conditions be remedied so that the medical schools may graduate their students at an earlier age.

In this connection, I quote from the 1918 report[1] of C. G. Schultz, superintendent of education of the state of Minnesota, now of the Government Department of Education, Washington:

"It requires a total school enrollment of approximately four hundred fifty to produce one college graduate. No one questions that it is desirable that this one graduate should be produced. But that a large part of the energies of a school community should be devoted to this end seems lacking in sound business sense. Surely such a procedure in no way contributes to the fulfillment of our democratic ideal of the open door to equal opportunity. In order that we may prepare one pupil for college we cannot justify the neglect of those forms of training distinctly desirable for the four hundred forty-nine who must follow pursuits other than those open to the college graduate. The same reasoning leads to the conclusion that we cannot justify our insistence upon the maintenance of high schools for the sole purpose of training all pupils to go to college when only one out of ten goes and only one out of thirty graduates."

The expense of our educational system is a serious burden on our taxation resources. By efficient methods a much greater percentage of our young people might secure higher education without an increase of the present burden. The average child should not be entered in the common school under the age of seven, but should be taught in the kindergarten, given six years in the grade school, and three in the high school. At sixteen the student who desires it is ready for university training. The freshman and sophomore years, under university supervision, may be given in the home high school under home influences. At the more mature age of 17 to 18 the students leave for the junior and senior years in the university. Such a program contemplates cutting only three years from the grade and high schools, does not increase the cost, and doubles the capacity of the university for the giving of advanced education. This is not purely theoretic; such university high school courses are now given

1. Twentieth Biennial Report, Department of Education, Minnesota, 1917-1918.

with university credits in some of the cities of Minnesota, among others Rochester, where C. H. Mayo, as one of the city school commissioners, has made the plan a success.

Another problem for which some wise solution must be found is the future management of the annual clinical meetings of the association. Even at the present time, with a limited membership, there are few cities in this country that can adequately care for the visitors at the meetings. It may be that a partial solution will be found in the development of clinical meetings to be held in various states or parts of the country in addition to the annual meeting for the convocation. It has also been suggested that the attendance at the annual meetings shall be limited to the members of the association, but, inasmuch as it is our intention to make the fellowship the first goal of the ambitious young surgeon after the completion of his training, it would seem that, so far as possible, promising young men should be admitted as invited guests.

In developing the sectional clinical meetings it should be borne in mind that the essential idea is educational — to develop better surgery. We must, however, remember that we, as a College, have a duty to perform to the public and to the profession, and this can best be brought about by close affiliation with the organizations representing medicine as a whole. We urge upon every Fellow that he become a member and a conscientious worker in his County and State Societies, and in the American Medical Association.

Men who cannot become fellows because of lack of moral character should not be allowed to give demonstrations or hold clinics under the auspices of the College.

Finally, I would call attention to the desirability of making the College of Surgeons truly American, by affiliation with the universities of the sister republics in South America. The University of Lima, Peru, is the oldest university in America, and many of the South American universities have attained pre-eminence as educational institutions, with whom it would be of great benefit to be associated. I am sure a way will be found to consummate so desirable an alliance.

PROPAGANDA FOR REFORM

A Pharmaceutical Clearing House.—The Council on Pharmacy and Chemistry of the American Medical Association is carrying on a work of great usefulness to doctor and layman. Actuated by no selfish interests, condemned by designing sharks who wish to exploit their frauds, and ridiculed by the jealous manufacturers of pharmaceuticals, the Council pursues the even tenor of its labors, playing no favorites, exposing frauds wherever found, and awaiting not the stamp of approval, of praise, or of gratitude from any one. This "clearing house" is the medium through which physicians may learn the unvarnished, straightforward truths about proprietary products. A plea of ignorance of proprietary articles used does not excuse the physician, since it is his duty to follow the course of instruction offered by the Council and to appeal to this clearing house for information. (*Southern Medical Journal*, September, 1919, p. 581.)

Lubricating Jelly. — The subjoined formula for an inexpensive lubricating jelly has been used in the German Hospital (now the Lankenau Hospital), Philadelphia, for a number of years: Tragacanth, whole, 3 gm.; glycerin, 25 c.c.; phenol, 1.5 gm.; distilled water to make 300 c.c. The tragacanth is broken in small pieces and put into a wide-mouthed bottle; the other ingredients are added and the bottle is frequently shaken. (*Jour. A. M. A.*, Dec. 13, 1919, p. 1852.)

The Prevention of Simple Goiter.—O. P. Kimball, J. M. Rogoff and D. Marine publish their third paper on the effect of sodium iodid in the prevention of goiter in school children. They conclude that simple goiter in man may be prevented and that the method may be carried out as a public health measure. Two gm. of sodium iodid given twice yearly seems adequate for the purpose. (*Jour. A. M. A.*, Dec. 20, 1919, p. 1873.)

More Misbranded Nostrums. — Rubino Healing Springs Lithia Water was found misbranded under the Federal Food and Drugs Act because it did not contain enough lithia to entitle it to the name "lithia water" and because of false claims as to its therapeutic value. Lower's Hot Springs Pure Blood Remedy was declared misbranded because it was freely represented to be a treatment or remedy for syphilis, paralysis, catarrh, eczema, malaria and other diseases. Analysis showed it to be a weak alcoholic solution containing sugars, small amounts of chlorides, iodides and sulphates (probably as the sodium salt), and vegetable extractives, among which are podophyllum and an atropin-bearing drug. Kuhn's Rheumatic Specific was declared misbranded because it was sold as a cure for all forms of rheumatism, neuralgia, blood diseases, lumbago, etc. It was found to be a water-alcohol solution containing essentially potassium iodid, iodin and sugar with indications of small amounts of plant material and aromatics. Schade's Specific and Female Regulator was declared misbranded because the therapeutic claims for this "female regulator" was found false. It was a water-alcohol solution containing chiefly sugar, aromatics, essential oils, licorice and bitter plant extractives. (*Jour. A. M. A.*, October 11, 1919, p. 1151.)

The William A. Webster Company and the Direct Pharmaceutical Company.— The Direct Pharmaceutical Company of St. Louis is apparently merely a sales agency for the William A. Webster Company of Memphis, Tenn. In government bulletins issued in October, 1913, there were reported some cases of adulteration and misbranding on the part of the William A. Webster Company. In a similar bulletin issued in August, 1914, there were reported several more cases of adulteration and misbranding charged against the William A. Webster Company. In a government bulletin issued in June, 1917, the same company was charged with adulterating and misbranding Aspirin tablets. (*Jour. A. M. A.*, October 18, 1919, p. 1231.)

Cancer Department

"In the early treatment of cancer lies the hope of cure"

AMERICAN SOCIETY FOR THE CONTROL OF CANCER

FACTS ABOUT CANCER.

Cancer is unquestionably increasing throughout the world.

At the beginning cancer is usually painless and difficult to detect.

At its first small growth it can be safely and easily removed by a competent surgeon.

Cancer is not a constitutional, or "blood" disease.

Cancer is not contagious.

Cancer is, practically speaking, not hereditary.

Every lump in the breast should be examined by a competent doctor.

Persistent abnormal discharge or bleeding is suspicious.

Sores, cracks, lacerations, lumps, and ulcers which do not heal, and warts, moles, or birthmarks which change in size, color, or appearance, may turn into cancer unless treated and cured.

Probably 60 per cent of cancers of the rectum are first regarded as piles. Insist on a thorough medical examination.

Continued irritation in some form is the usual cause of cancer. It rarely results from a sudden injury.

A doctor who treats a suspicious symptom without making a thorough examination does not know his business.

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Next Place of Meeting — DAYTONA — May, 1920

THE NEW BACCHUS.

No longer should artists—at least American artists—represent Bacchus astride a wine barrel; the little god should be depicted astraddle a "patent medicine" bottle. While no statistics are at hand — largely because those who could collect such statistics are not going to publish them—on the increase in the consumption of the numerous highly alcoholized "patent medicines" since the advent of national prohibition, there is no question that the sales of these products have been mightily augmented. As every physician and pharmacist knows, there are on the American market a number of widely advertised and extensively sold "patent medicines" whose most potent ingredient is alcohol. All such preparations, of course, contain, in addition to the alcohol, certain drugs on which the manufacturers base their therapeutic claims. These drugs, in nearly every instance, are either harmless or, if potent, are present in such small quantities as to have a negligible physiologic effect.

The problem of controlling the sale of these alcoholic medicines can be satisfactorily solved in only one way and that way is to prohibit the use of alcohol in preparations of the "home remedy" type, that is, in those products which are sold indiscriminately to the public for the self-treatment of disease. Such action has already been taken with reference to a drug like cocain, for instance, and in a modified form with reference to opium and its derivatives. Alcohol is a powerful drug. It is likely to be misused; so likely, in fact, that the United States has decided it is too dangerous to be used for beverage purposes. If alcohol is to be used for medicinal purposes it should be under medical supervision and the medical profession should be held as strictly accountable for any misuse of the drug as it is now held responsible for the misuse of the drugs covered by the Harrison Narcotic Law.

The manufacturers of "patent medicines" of the alcohol type all deny that the alcohol is present for its drug action; it is used as a "solvent" or as a "preservative" or "to

prevent freezing" or for some other reason. They argue that certain drugs can be extracted only by means of alcohol. This is true. It is equally true that after these substances have been so extracted, the alcohol can be evaporated and the drug principles that are left can be put up in the form of tablets or capsules. In many instances glycerin can be used as a solvent where a liquid medicine is desired.

One of the chief arguments put forth by the manufacturers of alcoholic "patent medicines" is of the *ad hominem* type. They declare that physicians prescribe tinctures, fluidextracts, etc., which contain alcohol in varying amounts. Very true. Physicians also prescribe such dangerous drugs as cocain, morphin, strychnin and arsenic, when in their judgment such drugs are indicated. This is no reason, however, why dangerous drugs should be sold indiscriminately to every Tom, Dick or Harry who has a pain or who, by reading nostrum advertisements, has been made to think he has a pain.

The nub of the whole thing is that none of these alcoholized "patent medicines" would have any vogue were the alcohol removed; neither would such removal affect the therapeutic value—real or supposititious—claimed for such products.—*Jour. A. M. A.*

A QUARTER CENTURY OF SERUM THERAPY IN DIPHTHERIA

In a recent address before the Académie de médecine of Paris, Louis Martin[1] recalled that in September, 1894, Roux communicated to a medical congress in Budapest the results of his pioneer studies on the serum therapy of diphtheria. To physicians of the present generation it seems long ago that Behring and his collaborators, Kitasato and Wernicke, definitely showed that the cell-free blood serum of animals immunized with diphtheria toxin acquires the power to protect other animals of the same and different species against the poison. Yet, in the quarter century that has elapsed since Roux put to the test of human clinical experience the treatment discovered by Behring, what enormous practical advantages to mankind have been derived from these brilliant scientific investigations. The outcome with the first larger group of diphtheria patients who received no other medical treatment than administration of antidiphtheritic serum was so striking that the procedure found prompt recognition from clinicians. Serum therapy in diphtheria became an accepted method. It is unnecessary to dwell on the fact that the mortality in this disease has been reduced from 30 per cent or more to 8 per cent or less in practice. The beneficent results can be learned from the experience of every community in the civilized world. The maximum of therapeutic efficiency has not yet been reached. With speedier diagnosis, with more direct methods of introducing the antitoxin, with better concentration and preparation of the latter, and with more heroic dosage in emergencies, the results seem destined to become even more favorable than they have been in the past. Now that the war is over and men can once more turn their thoughts to activities that are worth while, let us remember that the discovery of diphtheria antitoxin was not an overnight affair or a chance find. Only patient, laborious researches brought ultimate success. In the study of diphtheria, by which such brilliant results have been achieved, the laboratory and the clinic have worked hand in hand. Looking forward to further great discoveries in the domain of medicine, let us not fail to encourage in the case of other diseases likewise this fruitful collaboration between science and practice. —*Jour. A. M. A.*

1. Martin, Louis: Vingt-cinq annees de serotherapie antidiphtherique, Bull. de l'Acad. de med. 82: 173 (Oct. 14), 1919.

NEARLY 4,000 NURSES LISTED.

Miss Jane Hitchcock, chief of the Division of Public Health Nursing, of the Bureau of Information for Nurses, and Miss R. Inde Albaugh, chief of the Division of Institutional Assignment, reported to the Confer-

ence of Division Representatives of the Red Cross Department of Nursing, held at National Headquarters, November 17-22, that nearly 4,000 nurses have been entered in the files of the Red Cross Bureau of Information for Nurses.

"Jobs for Nurses and Nurses for Jobs" is still the slogan of this Bureau, established in February, 1919, to help nurses released from military service, both overseas and in this country, to enter those branches of the nursing profession which most interested them. Here, too, the Red Cross has cooperated with the American Nurses' Association, the National League of Nursing Education and the National Organization for Public Health Nursing, as well as in establishing close contact with the hospitals, institutions and public health agencies now so badly in need of nurses.

Miss Hitchcock, representing jointly the National Organization for Public Health Nursing and the American Red Cross, reported the demand for public health nurses "on the old gold fields of the Pacific Coast, in the rural districts of the Rocky Mountains, in the oil fields of New Mexico, Arizona and Oklahoma, in the southern mountains, at the little crossroads hamlets in the Middle West, in quaint, old-fashioned New England." To the nurse who loves outdoor life, her work in rural communities is one of constant interest and adventure. Sometimes she goes about her work in a Ford car; a saddle horse may carry her up the mountain trails to seek out an isolated case of tuberculosis. After she has won the confidence of her community, she becomes a beloved and honored member of it. Furthermore, her eight hours of duty allow her to have her own home and fireside, and her little vegetable and flower garden if she lives in the country."

"The Division of Public Health Nursing of the Bureau of Information for Nurses," continued Miss Hitchcock, "now has in its files the papers of 1,274 nurses interested in public health nursing. Many of these have already been referred to positions; others are now taking courses in public health nursing by means of the Red Cross scholarships and loan funds; still others are associated with the staffs of visiting nurse associations and preparing themselves for future work. In the meantime we are getting into communication with many public health agencies in all parts of the United States, and have many excellent opportunities for placing public health nurses."

Miss R. Inde Albaugh, chief of the Division of Institutional Assignment, to whom requests for nurses other than those interested in public health nursing are referred, reported on the activities of this Division.

"We have 2,353 names of nurses now represented in our files," Miss Albaugh stated, "and have also received 1,716 requests for nurses, including superintendents of hospitals and of training schools, instructors, supervisors, X-ray nurses, and practically every branch of the profession except public health nurses. Of these we have definite information that 805 nurses have accepted positions through this division. This number is in all probability much larger, as we have great trouble in making the nurses report back to us when they have accepted a position. We have also assigned 398 prospective student nurses to various hospitals. One of the sidelines which this division has developed has been that of interesting the Board of Military Relief and the Federal Board of Reeducation in the cases of nurses who have returned, incapacitated, from military service."—*The Red Cross Bulletin.*

NEW AND NONOFFICIAL REMEDIES

TUBERCULIN "B. E." (LEDERLE). — In addition to the forms previously described, New Tuberculin "B. E." (see New and Nonofficial Remedies, 1919, p. 280, and N. N. R. supplement, p. 10) is also marketed in packages containing a stated amount of tuberculin with sufficient diluent to make 1 c.c. as follows: Dilution A containing 0.1 c.c., Dilution B containing 0.01 c.c., Dilution C containing 0.001 c.c., Dilution D containing 0.0001 c.c., Dilution E containing 0.00001

c.c., Dilution F containing 0.000001 c.c. Lederle Antitoxin Laboratories, New York.

SODIUM DIOXIDE, DENTAL-R. AND H.—A brand of sodium peroxide complying with the New and Nonofficial Remedies standards, but containing at least 90 pr cent of sodium peroxide, and iron not to exceed 0.006 per cent. For a discussion of the actions and uses of sodium peroxide, see New and Nonofficial Remedies, 1919, p. 216. Roessler and Hasslacher Chemical Co., New York. (*Jour. A. M. A.*, Aug. 23, 1919, p. 607.)

TYPHOID-PARATYPHOID BACTERIN (SPECIAL BACTERIAL VACCINE NO. 13). — A typhoid vaccine (see New and Nonofficial Remedies, 1919, p. 292), marketed in 10-c.c. vials, each cubic centimeter containing 1,000 million killed B. Typhosus, 750 million killed B. Paratyphosus "A," and 750 million killed B. Paratyphosus "B." Fred I. Lackenbach, San Francisco.

TUBERCULIN "O. T." (LEDERLE). — Old Tuberculin (see New and Nonofficial Remedies, 1919, p. 277.) Marketed in packages containing a stated amount of tuberculin and sufficient diluent to make 1 c.c. as follows: Dilution A containing 0.1 c.c., Dilution B containing 0.01 c.c., Dilution C containing 0.001 c.c., Dilution D containing 0.0001 c.c., Dilution E containing 0.00001 c.c., Dilution F containing 0.000001 c.c. Lederle Antitoxin Laboratories, New York.

BENZYL ALCOHOL-VAN DYK. — A brand of benzyl alcohol which complies with the New and Nonofficial Remedies standards. For a description of the actions, uses and dosage of benzyl alcohol see New anl Nonofficial Remedies, 1919, p. 52. Van Dyk & Co., New York City.

CINCHOPHEN. — A nonproprietary name applied to phenylcinchoninic acid (Acidum Phenylcinchoninicum, U. S. P.) For a description of the actions, uses and dosage, see under Phenylcinchoninic Acid and Phenylcinchoninic Acid Derivatives, New and Nonofficial Remedies, 1919, p. 226.

CINCHOPHEN-ABBOTT.—The Abbott Laboratories have adopted the name cinchophen for the product accepted for New and Nonofficial Remedies as phenylcinchoninic acid-Abbott. (See New and Nonofficial Remedies, 1919, p. 227.)

CINCHOPHEN-MORGENSTERN. — Morgenstern and Company have adopted the terms cinchophen and sodium cinchophen water for the products accepted as acid. phenylcinch.-Morgenstern and sodium phenylcinch. water-Morgenstern. (See New and Nonofficial Remedies, 1919, p. 227.)

CINCHOPHEN-CALCO. — A brand of cinchophen. It complies with the standards for Acidum Phonylcinchoninicum, U. S. P. The Calco Chemical Co., Newark, N. J. (*Jour. A. M. A.*, Sept. 13, 1919, p. 837.)

CHLORAZENE SURGICAL GAUZE. — Gauze impregnated with, and containing approximately 5 per cent of chlorazene. For a description of chlorazene, see New and Nonofficial Remedies, 1919, p. 137. The Abbott Laboratories, Chicago.

SOY BEAN GRUEL FLOUR.—A flour prepared from the soy bean, having approximately the following composition: protein, 44; fat, 20; sucrose, 10; ash, 4.3; fiber, 2; water, 4.6. Soy bean gruel flour may be used for preparing muffins. It is indicated in cases in which a diet relatively free from carbohydrates is desired, as in diabetes, amylaceous dyspepsia, etc. It has also been suggested for the diet in obesity. Cereo Company, Tappan, N. J. (*Jour. A. M. A.*, October 18, 1919, p. 1215.)

HIRATHIOL. — An aqueous solution of a synthetic product, the important medicinal constituents of which are ammonium compounds containing sulphur in the form of sulphonates, sulphones and sulphides. It is claimed that hirathiol is equivalent in every respect to the original ichthyol; hence, its actions, uses and dosage should be similar to that of the older preparation (see Sulphoichthyolate Preparations, New and Nonofficial Remedies, 1919, p. 319). Hirathiol is a syrupy, brownish-black liquid, having a characteristic empyreumatic odor. It is soluble in water, glycerin and alcohol. It is miscible with fats. Takamine Laboratory, Inc., Clifton, N. J.

PUBLISHER'S NOTES.

HAND IN HAND.

One of the main reasons why there has been such a marked improvement in the wholesomeness and healthfulness in food products the last ten years has been on account of the cooperation between pure food officials, domestic science teachers, and the medical profession. These three elements have been working toward a common end—our protection against unscrupulous manufacturers who have not based their claims to business on the quality, but rather on cheapness and who, in their endeavor to market their products on price or quantity, have often resorted to substitution and to the use of unwholesome material. Though progress has been made, yet much remains to be done.

Mr. Harry L. Eskew, Food Commissioner of Tennessee, has been very active in his efforts to safeguard the health of the people of his State. In the *New York Journal of Commerce* he has the following to say about so-called Self-Rising Flour, which is used in certain sections:

"I would not tolerate flour products like some of the 'self-rising flour' sold in a large part of the South, the concomitants of which are alike unknown and not to be ascertained by the consumer and whose purity in the matter of phosphate is open to serious question as a deceptive agency."

When the need of improvement of certain food products is pointed out so definitely and at the same time is backed up by thousands of domestic science teachers throughout the country, it is quite natural that American housewives will gradually become schooled in the proper selection of food products, and at the same time demand proper labeling of all food products, and to gain this end, the medical profession will continue to play an important role.

The Abbott Laboratories of Chicago have been using half-page space in this Journal. Their success warrants them in using a full page at this time, and our readers will find their full-page announcement in this issue. This evidence that the readers of this Journal are careful to patronize our advertisers is gratifying, and is a tribute to the policy which this Journal long since adopted, of publishing in its advertising pages only such medical products as have been accepted by the Council on Pharmacy and Chemistry.

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